



COMMONWEALTH of VIRGINIA

Department of Health Professions
Board of Medicine

John W. Hasty
Director of the Department

Warren W. Koontz, M.D.
Executive Director of the Board

June 2, 1998

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Vincent J. Speckhart, M.D.
902 Graydon Avenue
Norfolk, Virginia 23507

CERTIFIED MAIL
Z 359 585 584

Re: License No.: 0101-020185

Dear Dr. Speckhart:

This letter is official notification that an informal conference of the Virginia Board of Medicine ("Board") will be held on July 24, 1998, at 9:00 a.m., at the Williamsburg Marriott, 50 Kingsmill Road, Williamsburg, Virginia. The conference will be conducted pursuant to Sections 54.1-2919 and 9-6.14:11 of the Code of Virginia (1950), as amended ("Code").

An Informal Conference Committee ("Committee"), composed of three members of the Board, will review your compliance with the terms and conditions of the Consent Order entered April 26, 1993; review the findings of the Audit Committee which evaluated your practice on November 25, 1997; receive and act upon evidence that you may have violated certain Terms of the Consent Order entered April 26, 1993, and certain laws and regulations governing the practice of medicine; and receive and act upon your petition for termination of probation. Specifically, you may have violated Term #2 of the Consent Order entered April 26, 1993, and Sections 54.1-2915.A(1), (4) and (3), as further defined in Sections 54.1-2914(A)(9), (10) and (13) of the Code, in that:

1. By Consent Order entered April 26, 1993, your license to practice medicine was placed on indefinite probation with certain terms and conditions due to your initiating as an adjunctive treatment to divers patients, immune alteration therapy using an autogenous vaccine regime which was derived from a urine or stool specimen taken from the patient, which was without accepted therapeutic purpose; using Electro-Acupuncture of Vol ("EAV"), an experimental diagnostic testing procedure, to diagnose and treat certain patients; using EAV testing without use of other diagnostic tests to diagnose ailments, develop treatment plans, and provide treatment; and failing to maintain complete and adequate patient medical records.
2. On or about August 11, 1995, you met with an informal conference committee of the Board to review your compliance with the terms of the April 26, 1993 Consent Order, to review the findings of the audit committee who assessed your practice, and to inquire into allegations that you may have violated certain laws governing the practice of medicine. By letter dated December 5, 1995, the Board notified you that the Committee ordered that your license be continued on indefinite probation pursuant to the terms of the April 26, 1993 Consent Order, and that a Medical Practices Audit Committee be appointed to evaluate your practice.

3. You have violated Term #2 of the Consent Order entered April 26, 1993, in that, you use and rely upon Electro-Acupuncture of Vol ("EAV"), an experimental diagnostic testing procedure, in the development of treatment plans and the diagnosis and treatment of medical conditions.
4. You have acted unprofessionally and not in the best interest of your patients, in that:
 - a. During the course of providing treatment to Patient One, whom you diagnosed as having recurrent grand mal seizures:
 - i. You failed to document whether the patient was receiving concurrent care for the seizures from another physician;
 - ii. You prescribed remedies to this patient as a result of EAV testing, and not from medically accepted diagnostic testing; and
 - iii. On or about September 2, 1997, this patient's record indicates he seized in the recent past to which a staff member recorded a change in the remedy prescription; however, there was no documentation to indicate that you had assessed the patient.
 - b. During the course of providing treatment to Patient Two, whom you diagnosed as having migraine headaches due to mercury poisoning, you improperly used EAV testing to arrive at said diagnosis and recommended remedies without conducting or recommending additional medically accepted testing to rule out or confirm said diagnosis.
 - c. During the course of providing treatment to Patient Three, who was diagnosed by another physician with lymphadenitis, probably bacterial, rule out Lyme disease, you improperly used EAV testing and recommended remedies based solely on EAV testing without conducting or recommending additional medically accepted testing to obtain a specific diagnosis, or refer this patient to another physician.
 - d. During the course of providing treatment to Patient Four, who was diagnosed with spinal stenosis by MR exam that might represent a cause of the patient's symptoms, you improperly used EAV testing and recommended remedies based solely on the EAV testing without conducting or recommending additional medically accepted testing, such as nerve conduction studies; and failed to discuss other treatment options such as surgical therapy or involvement of other neurologic or surgical physicians.
 - e. During the course of providing treatment to Patient Five, who presented to you one week post-surgery for breast cancer, you diagnosed her with cellulitis wound infection. You failed to document how you arrived at this diagnosis or the treatment plan.
 - f. During the course of providing treatment to Patient Six, who had advanced prostate cancer, you inappropriately discontinued his leuprolide therapy, prescribing DES instead, without adequately documenting the reason for the change. When questioned, you indicated that this patient had experienced a life threatening cardiac event related to the leuprolide treatment; however, leuprolide studies show an improved safety profile particularly with respects to cardiovascular complications as compared with DES.
 - g. During the course of providing treatment to Patient Seven, who had a long-standing history of hypertension, diabetes and, although poorly documented, coronary artery disease, you inappropriately recommended EDTA chelation therapy on the basis of a single hair sample, which you concluded showed increased lead and mercury. You failed to refer the hair sample to a standardized laboratory for confirmation; and failed to conduct routine laboratory testing or EKG testing. Further, you failed to refer this patient to another practitioner for concurrent care.

- h. During the course of providing treatment to Patient Eight, who had been diagnosed with macular degeneration, you inappropriately diagnosed that her eye disease had stabilized on therapy consisting of IV push therapy of selenium, and multivitamins, estriol and progesterone, after conducting only a fundoscopic examination. You failed to conduct any other testing or refer this patient for additional testing before rendering an opinion.
- i. During the course of providing treatment to Patient Nine, a 6 year old with a history of cystic fibrosis, you initiated EAV testing, increasing the duration of the sessions incrementally from thirteen to sixty-seven minutes and prescribed remedies. You failed to obtain x-rays, conduct routine laboratory testing or pulmonary function tests. This patient's record does not indicate that any other physician was providing concurrent care.
- j. You provide "remedies" to patients, which are predominantly homeopathic, based on the results of EAV testing or chelation therapy, without using accepted and medically appropriate diagnostic testing.
- k. You provide EAV testing under the guise of clinical research studies; however, you were unable to provide inclusion or exclusion criteria for the "studies," and indicated that all of your patients were appropriate for participation in the "research." Further, you were unable to provide any research protocol document describing the rationale, objectives, experimental design, and diagnostic and treatment plan for any recognized disease entity or for the research enterprise as a whole.
- l. You fail to provide adequate provisions for emergency care to patients.

As the Committee will be reviewing the findings of the Audit Committee, including findings relating to patients identified by you as Patients No. One through Nine, please bring to the conference the complete original patient records for Patients No. One through Nine for review.

The following actions may be taken by this Committee:

1. If a majority of the Committee is of the opinion that a suspension or revocation of your license may be justified, the Committee shall present to the Board in writing its findings, and the Board may proceed with a formal hearing;
2. The Committee may notify you in writing that you are fully exonerated of any charge that might affect your right to practice medicine in Virginia;
3. The Committee may reprimand or censure you;
4. The Committee may modify the terms and conditions of the probation for such time as it may designate and direct that during such period you furnish the Committee or its chairman, at such intervals as the Committee may direct, evidence that you are not practicing in violation of the provisions of Chapter 29, Title 54.1 of the Code, which governs the practice of medicine in Virginia; or

You have the right to information which will be relied upon by the Committee in making a decision. Therefore, I enclose a copy of the documents which will be distributed to the members of the Committee and will be considered by the Committee when discussing the allegations with you and when deliberating upon your case. These documents are enclosed only with the original notice sent by certified mail, and must be claimed at the post office. If you have additional documents for review which are not contained in this package, please bring at least six copies with you to the meeting. I also enclose relevant sections of the Administrative Process Act, which governs proceedings of this nature, as well as laws relating to the practice of medicine and other healing arts in Virginia.

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You may be represented by an attorney at the informal conference. Further, it is your responsibility to provide the enclosed materials to your attorney.

Should you fail to appear at the informal conference the Board may proceed to a formal administrative hearing in order to impose sanctions. Should you have any questions regarding this notice, please contact Assistant Attorney General Frank Pedrotty at (804) 786-7249 or Senior Legal Assistant Mary Beth Shelton at (804) 662-7084.

Sincerely,


Warren W. Koontz, M.D.
Executive Director
Virginia Board of Medicine

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cc: Paul M. Spector, D.O., President
John W. Hasty, Director, Department of Health Professions
James L. Banning, Director, Administrative Proceedings Division
Frank Pedrotty, Assistant Attorney General
Mary Beth Shelton, Senior Legal Assistant
Informal Conference Committee
Renee Dixon, Probation Review Analyst
Senior Administrative Assistant

Enclosures:

Virginia Code Sections:

54.1-2919

54.1-2915

54.1-2914

9-6.14:11

Informal Conference Package
Map